Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHEAST HEALTH SERVICES
PO BOX 170336
DALLAS TX 75217

Respondent Name
DALLAS ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-3402-01

MFDR Date Received
January 19, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 99070 was denied as 'invalid coding' however, the generic code 99070 was used because there was not a more descriptive code for the ace bandage given to the patient to help stabilize the injured area. Code 97039 was denied as 'invalid coding,' please see the attached documentation marked Exhibit 1 for clarification of this service. This claim was denied as 'not preauthorized' please see the attached proof of preauthorization with preauth # AP130163 and reprocess this claim for payment. Code 93799 was denied as 'global' please see the attached documentation marked Exhibit #2 for clarification of this service."

Amount in Dispute: $365.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No allowance is recommended for code 99070 billed on May 5, 2006. DWC rule 134.202 requires durable medical equipment supplies to be billed utilizing the HCPC codes. No allowance is recommended for code 97039 (miscellaneous code) for dates of service May 8,20, and June 1, 2006. The 2006 CPT codebook published by the American Medical Association list this procedure code under the category of constant attendance…The provider has failed to identify the use of this miscellaneous code on the CMS1500. The medical records appear to indicate this code is used for laser therapy. However, there is no time documented as required by the AMA coding guidelines. The May 16, 2006 authorization was for three additional visits of physical therapy. This covered the prior billed dates of service May 30, 31 and June 1, 2006. Since additional authorization for physical therapy was not obtained, no allowance is recommended for dates of service June 5,6, and June 9, 2006. No allowance is recommended for dates of service July 3, 2006 for procedure code 93799. The American Medical Association descriptor for this date of service is: Unlisted cardiovascular service or procedure. It is not within the scope of practice for a chiropractor to perform or bill any type of cardiovascular type of procedure. In additional, there were no medical records submitted with the dispute documenting heart monitoring."

Response Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2006	CPT Code 99070	$12.00	$0.00
May 8, 2006 May 30, 2006 June 1, 2006 June 5, 2006 June 6, 2006 June 9, 2006	CPT Code 97039	$20.00 x 6 = $120.00	$0.00
June 6, 2006	CPT Code 97140-59	$32.10	$0.00
June 6, 2006	CPT Code 97032	$19.58	$0.00
June 6, 2006	CPT Code 97016	$17.34	$0.00
June 6, 2006	CPT Code 97035	$14.86	$0.00
July 3, 2006	CPT Code 93799	$122.00	$0.00
TOTAL		$365.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. 28 Texas Administrative Code § 134.600, effective May 2, 2006, requires preauthorization for physical therapy services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 13, 2006
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - W1A, W1R-Workers compensation state fee schedule adjustment.
   - Reimbursement per Rule 134.202.
   - 56A-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
   - Incorrect CPT/HCPC code for this service/procedure.

   Explanation of benefits dated June 27, 2006
   - W1A-Workers compensation state fee schedule adjustment.
   - Reimbursement per Rule 134.202.
   - 56A-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
   - No evidence from published controlled clinical studies that this service has been proven safe and effective.

   Explanation of benefits dated June 29, 2006
   - W1A, W1R-Workers compensation state fee schedule adjustment.
   - Reimbursement per Rule 134.202.

- 56A-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
- No evidence from published controlled clinical studies that this service has been proven safe and effective.
- 62A-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Explanation of benefits dated July 5, 2006
- W1A, W1R-Workers compensation state fee schedule adjustment.
- Reimbursement per Rule 134.202.
- 56A-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
- No evidence from published controlled clinical studies that this service has been proven safe and effective.
- Incorrect CPT/HCPC code for this service/procedure.

Explanation of benefits dated August 4, 2006
- W1A-Workers compensation state fee schedule adjustment.
- Reimbursement per Rule 134.202.
- 97H-Payment is included in the value of another service/procedure.
- Service(s)/Procedure is included in the value of another service/procedure billed on the same date.

Explanation of benefits dated October 9, 2006
- W4, W4C-No additional reimbursement allowed after review of appeal/reconsideration.
- Documentation does not justify the level of service billed.
- W1R-Workers compensation state fee schedule adjustment.
- Incorrect CPT/HCPC code for this service/procedure.

Explanation of benefits dated October 18, 2006
- 18-Duplicate claim/service.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 56A-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
- No evidence from published controlled clinical studies that this service has been proven safe and effective.
- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 97H-Payment is included in the value of another service/procedure.
- Service(s)/Procedure is included in the value of another service/procedure billed on the same date.

Issues

1. Is the requestor entitled to reimbursement for CPT code 99070?
2. Does a preauthorization issue exist in this dispute regarding physical therapy services rendered on June 5, 6, and June 9, 2006?
3. Did the requestor support position that amount sought in reimbursement for CPT code 97039 rendered on May 8, May 30, June 1 and June 5, 2006 is fair and reasonable?
4. Is the requestor entitled to reimbursement for CPT code 93799?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99070 based upon reason codes: "W1R-Workers compensation state fee schedule adjustment and Incorrect CPT/HCPC code for this service/procedure."

   CPT code 99070 is defined as "Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)."

   The requestor states in the position summary that "Code 99070 was denied as 'invalid coding' however, the generic code 99070 was used because there was not a more descriptive code for the ace bandage given to the patient to help stabilize the injured area."

   The respondent states in the position summary that "No allowance is recommended for code 99070 billed on May 5, 2006. DWC rule 134.202 requires durable medical equipment supplies to be billed utilizing the HCPC codes."

Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

A review of Medicare's HCPCS lists codes for Self-Adhesive bandages; therefore, the insurance carrier's denial based upon invalid coding is supported. As a result, no reimbursement is recommended.

2. According to the explanation of benefits, the respondent denied physical therapy services coded 97039, 97014-59, 97032, 97016, and 97035 based upon reason code "62A-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization".

The requestor states in the position summary that "This claim was denied as 'not preauthorized' please see the attached proof of preauthorization with preauth # AP130163 and reprocess this claim for payment".

The respondent states in the position summary that "The May 16, 2006 authorization was for three additional visits of physical therapy. This covered the prior billed dates of service May 30, 31 and June 1, 2006. Since additional authorization for physical therapy was not obtained, no allowance is recommended for dates of service June 5,6, and June 9, 2006."

28 Texas Administrative Code § 134.600(p) states "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
(i) Modalities, both supervised and constant attendance;
(ii) Therapeutic procedures, excluding work hardening and work conditioning;
(iii) Orthotics/Prosthetics Management;
(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code.

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
(i) the date of injury, or
(ii) a surgical intervention previously preauthorized by the carrier"

The requestor submitted a copy of a preauthorization report dated May 16, 2006 that gave authorization for "3 ADDITIONAL PHYSICAL THERAPY VISITS COMPLETED AFTER 5/19/06 FOR A TOTAL OF 9 VISITS (THIS INCLUDES THE 6 INITIAL VISITS NOT REQUIRING PREAUTH)."

A review of the submitted medical records indicates that claimant received physical therapy on May 30, June 1, and June 5, 2006; therefore, date of service June 6, 2006 is beyond the three days preauthorized; therefore, reimbursement cannot be recommended for the physical therapy services rendered on June 6, 2006.

3. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

CPT code 97039 is defined as "Unlisted modality (specify type and time if constant attendance)." The requestor noted that CPT code 97039 was used for coding laser therapy.

CPT code 97039 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if

available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Code 97039 was denied as 'invalid coding,' please see the attached documentation marked Exhibit 1 for clarification of this service."
- The requestor does not discuss or explain how reimbursement of $20.00 for code 97039 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

4. According to the explanation of benefits, the respondent denied reimbursement for CPT code 93799 based upon reason codes "97H-Payment is included in the value of another service/procedure, and Service(s)/Procedure is included in the value of another service/procedure billed on the same date."

   CPT code 93799 is defined as "Unlisted cardiovascular service or procedure".

   The requestor states in the position summary that "Code 93799 was denied as 'global' please see the attached documentation marked Exhibit #2 for clarification of this service." Exhibit 2 indicates that code 93799 was billed for heart monitoring.

   The respondent states in the position summary that "No allowance is recommended for dates of service July 3, 2006 for procedure code 93799. The American Medical Association descriptor for this date of service is: Unlisted cardiovascular service or procedure. It is not within the scope of practice for a chiropractor to perform or bill any type of cardiovascular type of procedure. In additional, there were no medical records submitted with the dispute documenting heart monitoring."

   A review of the submitted medical bill finds that on July 3, 2006 the requestor billed for a functional capacity test, CPT code 97750-FC, in conjunction with CPT code 93799. The requestor did not submit a copy of the heart monitoring report to support that it was not inclusive with the testing; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		1/09/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.